

***FRAMEWORK FOR STATE EVALUATION  
OF CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT***

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: \_\_\_\_\_ Vermont \_\_\_\_\_  
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the  
Social Security Act (Section 2108(b)).

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Date: 4/14/00

Reporting Period: 10/1/98-9/30/99

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Developed by the National Academy for State Health Policy

## SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

- 1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

**6,047**

- 1.1.1 What are the data source(s) and methodology used to make this estimate?

**This estimate was based on data from the Vermont Banking, Insurance, Securities, and Health Care Administration (BISHCA) administered 1997 Vermont Family Health Insurance Survey.**

- 1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

**The 1997 survey was small - data was collected from 1,033 families and 2,316 individuals.**

- 1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

**The number of children enrolled in the SCHIP program as of 9/30/99 = 1,271**

- 1.2.1 What are the data source(s) and methodology used to make this estimate?

**The data source is an eligibility report that is created monthly from our eligibles file.**

**9/30/98 SCHIP eligibles = 0, 9/30/99 SCHIP eligibles = 1,271**

- 1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

**The eligibility report is an accurate count of SCHIP eligibles.**

- 1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

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For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
<b>OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN</b>		
<b>Reduce the number of uninsured children in the State</b>	<b>Reduce percentage of uninsured children from 4% to 3% by FFY 2001</b>	<p>Data Sources: <b>Vermont's MMIS</b></p> <p>Methodology: <b>1997 Vermont Health Insurance to Survey Compared to current enrollees</b></p> <p>Numerator: <b>1,271</b></p> <p>Denominator: <b>1,100</b></p> <p>Progress Summary: <b>6,047 projected as uninsured children. Anticipating 1,100 enrollments by FFY 2001. Represents. 1% reduction of uninsured. As of 9/30/99 we have enrolled 1,271 children, a 1.2% reduction in FFY 1999.</b></p>

**Table 1.3****OBJECTIVES RELATED TO CHIP ENROLLMENT**

<b>Improve access to care</b>	<b>Increase access by enrolling SCHIP children in MCOs where each eligible will have access to a primary care physician</b>	<p>Data Sources: <b>Vermont's MMIS</b></p> <p>Methodology: <b>Compare the numbers of MCO enrollees to FFS enrollees</b></p> <p>Numerator: <b>974</b></p> <p>Denominator: <b>1,271</b></p> <p>Progress Summary: <b>As of 9/30/99 -- 76.6% in MCOs. Of 1,271 children, 974 enrolled in MCOs and 297 were in the FFS program. Note: By 9/99 it was known that one of our two MCOs would cease operation by 1/1/00 and contact negotiations with the remaining MCO were uncertain. We discontinued enrolling new eligibles in MCOs effective 7/1/99 per agreements with these MCOs.</b></p>
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**Table 1.3****OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT**

<b>Improve service coordination through managed care enrollment</b>	<b>Our goal is to enroll 60% of all SCHIP children in an MCO no later than the second month after eligibility determination and the remainder of participants no later than the third month</b>	Data Sources: <b>Vermont's MMIS</b>  Methodology: <b>Automated referral process.</b>  Numerator: <b>N/A</b>  Denominator: <b>N/A</b>  Progress Summary: <b>As of 9/30/99 --- 974 children were enrolled in MCOs in comparison to 0 on 9/30/98. Note again that new referrals were discontinued as of 7/1/99 as a result of contact agreements with the two MCOs.</b>
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**OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)**

<b>Improve care through the offering of health insurance</b>	<b>To increase the percentage of 2 year old children who are fully immunized for 84% to 90%</b>	Data Sources: <b>Vermont Department of Health</b>  Methodology:  Numerator:  Denominator:  Progress Summary: <b>Unknown</b>
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<b>Table 1.3</b>		
<b>OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)</b>		
		Data Sources:  Methodology:  Numerator:  Denominator:  Progress Summary:
<b>OTHER OBJECTIVES</b>		
		Data Sources:  Methodology:  Numerator:  Denominator:  Progress Summary:

## SECTION 2. BACKGROUND

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This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

☐ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: \_\_\_\_\_

Date enrollment began (i.e., when children first became eligible to receive services): \_\_\_\_\_

☒ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: **Dr. Dynasaur. Until 1989 we offered health care as Medicaid only. In 1989 we introduced a state-only program for children's health care coverage called Dr. Dynasaur. In 1992 it became part of Medicaid using 1902(r)(2) income disregards. As part of an effort to encourage participation and de-link coverage from the concept of "welfare" we encouraged a public perception that all children's coverage was Dr. Dynasaur. This continued with the implementation of SCHIP and the concurrent implementation of Medicaid coverage for underinsured children in the same income range using those same income disregards option and the authority of Vermont's 1115 demonstration project.**

Date enrollment began (i.e., when children first became eligible to receive services): **10/1/98**

☐ Other - Family Coverage

Name of program: \_\_\_\_\_

Date enrollment began (i.e., when children first became eligible to receive services): \_\_\_\_\_

\_\_\_ Other - Employer-sponsored Insurance Coverage

Name of program: \_\_\_\_\_

Date enrollment began (i.e., when children first became eligible to receive services): \_\_\_\_\_

\_\_\_ Other - Wraparound Benefit Package

Name of program: \_\_\_\_\_

Date enrollment began (i.e., when children first became eligible to receive services): \_\_\_\_\_

\_\_\_ Other (specify) \_\_\_\_\_

Name of program: \_\_\_\_\_

Date enrollment began (i.e., when children first became eligible to receive services): \_\_\_\_\_

2.1.2 If State offers family coverage: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.1.3 If State has a buy-in program for employer-sponsored insurance: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.2 What environmental factors in your State affect your CHIP program?  
(Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

**The SCHIP population uses the same covered services benefit package and service delivery systems as are used for Medicaid/Dr. Dynasaur.**

2.2.2 Were any of the preexisting programs “State-only” and if so what has happened to that program?

X   No pre-existing programs were “State-only”

       One or more pre-existing programs were “State only” ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

- 2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that “affect the provision of accessible, affordable, quality health insurance and healthcare for children.” (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

\_\_\_ Changes to the Medicaid program **Prior to SCHIP**

- \_\_\_ Presumptive eligibility for children
- \_\_\_ Coverage of Supplemental Security Income (SSI) children
- \_\_\_ Provision of continuous coverage (specify number of months \_\_\_ )
- \_\_\_ Elimination of assets tests
- \_\_\_ Elimination of face-to-face eligibility interviews
- \_\_\_ Easing of documentation requirements

\_\_\_ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify) **Prior to SCHIP**

☒ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- ☒ Health insurance premium rate increases **News account**
- \_\_\_ Legal or regulatory changes related to insurance
- \_\_\_ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- \_\_\_ Changes in employee cost-sharing for insurance
- \_\_\_ Availability of subsidies for adult coverage
- \_\_\_ Other (specify) \_\_\_\_\_

\_\_\_ Changes in the delivery system

- \_\_\_ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- \_\_\_ Changes in hospital marketplace (e.g., closure, conversion, merger)
- \_\_\_ Other (specify) \_\_\_\_\_

\_\_\_ Development of new health care programs or services for targeted low-income children (specify) \_\_\_\_\_

\_\_\_ Changes in the demographic or socioeconomic context

- \_\_\_ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) \_\_\_\_\_

- \_\_\_ Changes in economic circumstances, such as unemployment rate  
(specify)\_\_\_\_\_
- \_\_\_ Other (specify)\_\_\_\_\_
- \_\_\_ Other (specify) \_\_\_\_\_

## SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

### 3.1 Who is eligible?

- 3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter “NA.”

<b>Table 3.1.1</b>			
	<b>Medicaid CHIP Expansion Program</b>	<b>State-designed CHIP Program</b>	<b>Other CHIP Program*</b> _____ _____
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))		<b>Statewide</b>	
Age		<b>&lt;18</b>	
Income (define countable income)		<b>225%-300% see attached</b>	
Resources (including any standards relating to spend downs and disposition of resources)		<b>No limits</b>	
Residency requirements		<b>None</b>	
Disability status		<b>None</b>	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))		<b>Creditable coverage makes ineligible for SCHIP</b>	
Other standards (identify and describe)		<b>None</b>	

*\*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.*

### 3.1.2 How often is eligibility redetermined?

<b>Table 3.1.2</b>			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Monthly			
Every six months		<b>If the parents are on Vermont Health Access Plan (VHAP)</b>	
Every twelve months		<b>If parents are not VHAP</b>	
Other (specify)			

\*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

### 3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

☒ Yes Which program(s)? **SCHIP when first enrolled with an MCO .**

For how long? **6 months**

☐ No

### 3.1.4 Does the CHIP program provide retroactive eligibility?

☒ Yes ☐ Which program(s)? **SCHIP**

How many months look-back? **3 months prior to application**

☐ No

### 3.1.5 Does the CHIP program have presumptive eligibility?

☐ Yes ☐ Which program(s)?

Which populations?

Who determines?

**X** No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

☒ Yes ☐ No Is the joint application used to determine eligibility for other State programs? If yes, specify. **Medicaid/Dr. Dynasaur and WIC.**

☐ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

**Strengths:**

**Applicants are not required to come to any office for an interview, and instead may apply by mail.**

**Families who wish to apply only for health care benefits have their application processed by a centralized unit, which has no overt connection to the welfare department nor any resulting perceived stigma.**

**For the past 10 years Vermont has used a simplified, shorter application form for children's enrollment.**

**This abbreviated form also serves as a joint application for WIC benefits. WIC staff screen for and encourage application for Dr. Dynasaur, mailing completed applications to DSW for processing.**

**Self-declaration is accepted with verification required only for social security numbers, pregnancy, disability and questionable circumstances.**

**There continues to be no assets test for Dr. Dynasaur (including SCHIP) eligibility.**

**The income test (300% of FPL) is consistent across children of all ages, up to age 18 regardless of funding source.**

**SCHIP and VT's Medicaid/Dr. Dynasaur program are fully integrated. Families apply using the same application form, processing staff are trained in all health care programs, and the computer system tests for eligibility and interfaces with other programs.**

**Applicants may call a toll-free number with questions on eligibility rules, to request an application or for help to complete one.**

**Weaknesses:**

**Materials are not (yet) published in different languages.**

**We are working to better publicize the availability of this program, especially to those families with higher incomes and/or other insurance.**

- 3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

**The process to redetermine eligibility is similar to that described above for initial application. It differs in that recipients are mailed a redetermination letter and a short application form six weeks before the end of the certification period. If the completed form isn't received within three weeks, a reminder notice is sent.**

- 3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.



**Table 3.2.1 CHIP Program Type**

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	<b>X</b>	<b>None</b>	
Emergency hospital services	<b>X</b>	<b>None</b>	
Outpatient hospital services	<b>X</b>	<b>None</b>	
Physician services	<b>X</b>	<b>None</b>	
Clinic services	<b>X</b>	<b>None</b>	
Prescription drugs	<b>X</b>	<b>None</b>	
Over-the-counter medications	<b>X</b>	<b>None</b>	<b>PA required</b>
Outpatient laboratory and radiology services	<b>X</b>	<b>None</b>	
Prenatal care	<b>X</b>	<b>None</b>	
Family planning services	<b>X</b>	<b>None</b>	
Inpatient mental health services	<b>X</b>	<b>None</b>	<b>PA required</b>
Outpatient mental health services	<b>X</b>	<b>None</b>	
Inpatient substance abuse treatment services	<b>X</b>	<b>None</b>	<b>PA required</b>
Residential substance abuse treatment services	<b>X</b>	<b>None</b>	<b>PA required</b>
Outpatient substance abuse treatment services	<b>X</b>	<b>None</b>	
Durable medical equipment	<b>X</b>	<b>None</b>	<b>PA required for some items</b>
Disposable medical supplies	<b>X</b>	<b>None</b>	

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Preventive dental services	<b>X</b>	<b>None</b>	
Restorative dental services	<b>X</b>	<b>None</b>	
Hearing screening	<b>X</b>	<b>None</b>	
Hearing aids	<b>X</b>	<b>None</b>	<b>Digital require PA</b>
Vision screening	<b>X</b>	<b>None</b>	<b>One comprehensive and interim exam every 24 months</b>
Corrective lenses (including eyeglasses)	<b>X</b>	<b>None</b>	<b>One pair every 2 years unless a 1/2 diopter change</b>
Developmental assessment	<b>X</b>	<b>None</b>	
Immunizations	<b>X</b>	<b>None</b>	
Well-baby visits	<b>X</b>	<b>None</b>	
Well-child visits	<b>X</b>	<b>None</b>	
Physical therapy	<b>X</b>	<b>None</b>	<b>PA after 1<sup>st</sup> 4 months</b>
Speech therapy	<b>X</b>	<b>None</b>	<b>PA after 1<sup>st</sup> 4 months</b>
Occupational therapy	<b>X</b>	<b>None</b>	<b>PA after 1<sup>st</sup> 4 months</b>
Physical rehabilitation services	<b>X</b>	<b>None</b>	
Podiatry services	<b>X</b>	<b>None</b>	<b>Routine foot care is not covered</b>
Chiropractic services	<b>X</b>	<b>None</b>	<b>PA required for all children under 12</b>
Medical transportation	<b>X</b>	<b>None</b>	
Home health services	<b>X</b>	<b>None</b>	
Nursing facility	<b>X</b>	<b>None</b>	<b>PA required</b>
ICF/MR	<b>X</b>	<b>None</b>	<b>PA required</b>

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Hospice care	<b>X</b>	<b>None</b>	
Private duty nursing	<b>X</b>	<b>None</b>	<b>PA required</b>
Personal care services	<b>X</b>	<b>None</b>	<b>PA required</b>
Habilitative services			
Case management/Care coordination			
Non-emergency transportation	<b>X</b>		
Interpreter services	<b>X</b>	<b>None</b>	
Other (Specify)			
Other (Specify)			
Other (Specify)			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

### 3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

**All SCHIP beneficiaries are provided the same health coverage as all Dr. Dynasaur beneficiaries.**

### 3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

<b>Table 3.2.3</b>			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)		<b>Yes</b>	
Statewide?	___ Yes ___ No	<b>X</b> Yes ___ No	___ Yes ___ No
Mandatory enrollment?	___ Yes ___ No	<b>X</b> Yes ___ No	___ Yes ___ No
Number of MCOs		<b>2</b>	
B. Primary care case management (PCCM) program		<b>No</b>	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)		<b>No</b>	
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)		<b>Chiropractic, Dental , Eyeglasses, Family Planning</b>	
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

\*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

### 3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost Developed by the National Academy for State Health Policy

sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

\_\_\_ No, skip to section 3.4

**X** Yes, check all that apply in Table 3.3.1

<b>Table 3.3.1</b>			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____
Premiums		N/A	
Enrollment fee		<b>\$20 per month/per family</b>	
Deductibles		N/A	
Coinsurance/copayments**		N/A	
Other (specify) _____			

\*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

\*\*See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

- \_\_\_ Employer
- \_\_\_ Family
- \_\_\_ Absent parent
- \_\_\_ Private donations/sponsorship
- \_\_\_ Other (specify) \_\_\_\_\_

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how

does it vary by program, income, family size, or other criteria?

**Enrollment fee is \$20 per month/per family. There is no variation.**

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

**Families are not notified of the 5 percent cap due to the fact that based on the enrollment fee of \$20 per month/per family the maximum per year will not exceed \$240 which is less than 5% of the income at 225% of the FPL.**

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

☐ Shoebox method (families save records documenting cumulative level of cost sharing)

☐ Health plan administration (health plans track cumulative level of cost sharing)

☐ Audit and reconciliation (State performs audit of utilization and cost sharing)

☒ Other (specify)

**Program fees cannot exceed 5 percent of family income. See response to 3.3.6**

3.3.7 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

**None**

3.3.8 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

**No assessment.**

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (X=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

**Table 3.4.1**

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	X = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Billboards			<b>No</b>			
Brochures/flyers			<b>X</b>	<b>3</b>		
Direct mail by State/enrollment broker/administrative contractor			<b>X</b>	<b>4-5</b>		
Education sessions			<b>X</b>	<b>3</b>		
Home visits by State/enrollment broker/administrative contractor			<b>X</b>	<b>2</b>		
Hotline			<b>X</b>	<b>4</b>		
Incentives for education/outreach staff			<b>No</b>			
Incentives for enrollees			<b>No</b>			
Incentives for insurance agents			<b>No</b>			
Non-traditional hours for application intake			<b>X</b>	<b>3</b>		
Prime-time TV advertisements			<b>No</b>			
Public access cable TV			<b>No</b>			
Public transportation ads			<b>No</b>			
Radio/newspaper/TV advertisement and PSAs			<b>X</b>	<b>3</b>		

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Signs/posters			<b>X</b>	<b>3</b>		
State/broker initiated phone calls			<b>No</b>			
Other (specify)						
Other (specify)						

\*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (X=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

<b>Table 3.4.2</b>						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	X = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters			<b>X</b>	<b>2</b>		
Community sponsored events			<b>X</b>	<b>3</b>		
Beneficiary's home			<b>X</b>	<b>5</b>		
Day care centers			<b>X</b>	<b>2</b>		
Faith communities						
Fast food restaurants						
Grocery stores			<b>X</b>	<b>1</b>		
Homeless shelters			<b>X</b>	<b>2</b>		
Job training centers			<b>X</b>	<b>3</b>		
Laundromats			<b>X</b>	<b>1</b>		
Libraries			<b>X</b>	<b>1</b>		
Local/community health centers			<b>X</b>			
Point of service/provider locations						
Public meetings/health fairs			<b>X</b>	<b>4</b>		
Public housing						

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Refugee resettlement programs			<b>X</b>	<b>3</b>		
Schools/adult education sites			<b>X</b>	<b>3</b>		
Senior centers			<b>X</b>	<b>3</b>		
Social service agency			<b>X</b>	<b>4</b>		
Workplace			<b>X</b>	<b>2</b>		
Other (specify)						
Other (specify)						

\*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

**3.4.3** Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available. **None**

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds? **None**

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available. **None**

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

<b>Table 3.5</b>				
Type of coordination	Medicaid*	Maternal and child health	Other (specify) _____	Other (specify) _____
Administration	<b>X</b>			
Outreach	<b>X</b>			
Eligibility determination	<b>X</b>			
Service delivery	<b>X</b>			
Procurement	<b>X</b>			
Contracting	<b>X</b>			
Data collection	<b>X</b>			
Quality assurance	<b>X</b>			
Other (specify)				
Other (specify)				

\*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

**\*Due to the size of the SCHIP program all administration is shared with Medicaid/Dr. Dynasaur.**

3.5 How do you avoid crowd-out of private insurance?

**One month waiting period. Children with insurance coverage at the same income level are eligible as Medicaid/Dr.Dynasaur under the 1115 waiver with a reduced premium of \$10 per month/per family.**

- 3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

\_\_\_ Eligibility determination process:

- ☒ Waiting period without health insurance (specify) **One Month**
- ☒ Information on current or previous health insurance gathered on application (specify) **Self-declaration**
- \_\_\_ Information verified with employer (specify)
- \_\_\_ Records match (specify)
- ☒ Other (specify) **Children with insurance are covered under the 1115 waiver with a reduced premium of \$10 per month/per family**
- \_\_\_ Other (specify)

\_\_\_ Benefit package design:

- \_\_\_ Benefit limits (specify)
- \_\_\_ Cost-sharing (specify)
- \_\_\_ Other (specify)
- \_\_\_ Other (specify)

\_\_\_ Other policies intended to avoid crowd out (e.g., insurance reform):

- \_\_\_ Other (specify)
- \_\_\_ Other (specify) \_\_\_\_\_

- 3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

**With the size of our SCHIP program there is no justification for a special effort to monitor crowd-out.**

## SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

### 4.1 Who enrolled in your CHIP program?

#### 4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

**NOTE:** To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

**See attached tables representing preliminary reporting on this information. This is quarterly information. Annual information will be supplied. Note that SCHIP coverage in Vermont is from 225% to 300% of FPL with a single program fee for the entire income bracket.**

<b>Table 4.1.1 CHIP Program Type</b> _____						
Characteristics	Number of children Ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
<b>All Children</b>						
<b>Age</b>						
Under 1						
1-5						

6-12						
13-18						
<b>Countable Income Level*</b>						
At or below 150% FPL						
Above 150% FPL						
<b>Age and Income</b>						
Under 1						
At or below 150% FPL						
Above 150% FPL						
1-5						
At or below 150% FPL						
Above 150% FPL						
6-12						
At or below 150% FPL						
Above 150% FPL						
13-18						
At or below 150% FPL						
Above 150% FPL						
<b>Type of plan</b>						
Fee-for-service						
Managed care						
PCCM						

\*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

- 4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

**Unknown.**

- 4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

**There are no other public or private programs. As a State we have consciously chosen to use Dr. Dynasaur coverage as the center point for affordable coverage for children. This is a collaborative effort. For example, in August, 1999, the Department of Health in partnership with the Department of Education sent letters to the families of every school age child in Vermont via the School districts notifying them of the Dr. Dynasaur program (including SCHIP). This notice resulted in a 50% increase in applications and a 30% increase in phone calls to our Member services unit (MAXIMUS).**

- 4.2 Who disenrolled from your CHIP program and why?

- 4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

**Looking at those eligible in one quarter and those no longer eligible in the subsequent quarter we found 52 of 370 disenrolled in the 1<sup>st</sup> Q, 164 of 907 in the 2<sup>nd</sup>, 292 of 1207 in the 3<sup>rd</sup>, and 314 of 1483 in the fourth. We had no particular expectations on disenrollment and we have not completed our data review of closure reasons that this time.**

**At our Vermont income levels, 225% - 300% of the FPL, this is not a poor peoples program. We are seeing middle class families. It appears that many such households with uninsured children might feel that handling routine care costs without insurance is not a burden. SCHIP and the Medicaid/Dr. Dynasaur utilization for the underinsured children in the**

same income brackets do not suggest that there were significant previously unmet needs prior to coverage.

**It appears that SCHIP and the Medicaid expansion has presented an opportunity to have coverage in case it is needed. While we behave increasingly like an insurance company we still operate like a welfare program. For example an insurance company only provides coverage upon premium payment. We bill for program fees after a period of coverage to assure that they are eligible in the period. This gives families a chance to "try out" coverage with no expense, to see if it is "worth it". We also readily allow application for benefits for past periods. Thus, our insurance provides a unique service, episodic coverage, where families can obtain coverage only when they need it. To illustrate, in one analysis, we found that 64.1% of those SCHIP eligibles who closed for not paying the enrollment fee in June, 1999 were reinstated within six months.**

- 4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

**Preliminary information suggests that the majority of closures are for not completing a review, failing to provide requested information, or non-payment of premiums but we also find that beneficiaries are routinely subsequently reinstated. To date, we have not felt that the size of the program and the number of disenrollments justify follow up. Note that a beneficiary who obtains insurance in this income bracket may continue to be eligible for coverage under our Medicaid/Dr. Dynasaur expansion between 225% and 300% of the FPL.**

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

**Report Tables to follow.**

<b>Table 4.2.3</b>						
Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total						
Access to commercial insurance						
Eligible for Medicaid						
Income too high						
Aged out of program						
Moved/died						
Nonpayment of premium						
Incomplete documentation						
Did not reply/unable to contact						
Other (specify)						
Other (specify)						
Don't know						

\*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

- 4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

**We depend on families to reapply. See also 4.2.1**

- 4.3 How much did you spend on your CHIP program?

- 4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 \_\_\_\_\_ **\$0** \_\_\_\_\_

FFY 1999 \_\_\_\_\_ **\$714,941** \_\_\_\_\_

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

<b>Table 4.3.1 CHIP Program Type</b> _____				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
<b>Total expenditures</b>	<b>0</b>	<b>\$714,941</b>	<b>0</b>	<b>\$524,624</b>
<b>Premiums for private health insurance (net of cost-sharing offsets)*</b>	<b>0</b>	<b>\$396,135</b>	<b>0</b>	<b>\$290,684</b>
<b>Fee-for-service expenditures (subtotal)</b>	<b>0</b>	<b>\$318,806</b>	<b>0</b>	<b>\$233,940</b>
Inpatient hospital services	<b>0</b>	<b>\$17,561</b>	<b>0</b>	<b>\$12,886</b>
Inpatient mental health facility services	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Nursing care services	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Physician and surgical services	<b>0</b>	<b>\$21,332</b>	<b>0</b>	<b>\$15,653</b>
Outpatient hospital services	<b>0</b>	<b>\$9,412</b>	<b>0</b>	<b>\$6,907</b>
Outpatient mental health facility services	<b>0</b>	<b>\$30,565</b>	<b>0</b>	<b>\$22,429</b>

Prescribed drugs	<b>0</b>	<b>\$75,553</b>	<b>0</b>	<b>\$55,441</b>
Dental services	<b>0</b>	<b>\$89,612</b>	<b>0</b>	<b>\$65,757</b>
Vision services	<b>0</b>	<b>\$2,312</b>	<b>0</b>	<b>\$1,697</b>
Other practitioners' services	<b>0</b>	<b>\$794</b>	<b>0</b>	<b>\$583</b>
Clinic services	<b>0</b>	<b>\$49,513</b>	<b>0</b>	<b>\$36,333</b>
Therapy and rehabilitation services	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Laboratory and radiological services	<b>0</b>	<b>\$118</b>	<b>0</b>	<b>\$87</b>
Durable and disposable medical equipment	<b>0</b>	<b>\$291</b>	<b>0</b>	<b>\$214</b>
Family planning	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Abortions	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Screening services	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Home health	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Home and community-based services	<b>0</b>	<b>\$6,380</b>	<b>0</b>	<b>\$4,682</b>
Hospice	<b>0</b>	<b>\$119</b>	<b>0</b>	<b>\$87</b>
Medical transportation	<b>0</b>	<b>\$367</b>	<b>0</b>	<b>\$269</b>
Case management	<b>0</b>	<b>\$5,606</b>	<b>0</b>	<b>\$4,114</b>
Other services	<b>0</b>	<b>\$9,271</b>	<b>0</b>	<b>\$6,803</b>

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? **N/A**

What role did the 10 percent cap have in program design?

**N/A**

<b>Table 4.3.2</b>						
Type of expenditure	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
<b>Total computable share</b>						
Outreach						
Administration						
Other _____						
<b>Federal share</b>						
Outreach						
Administration						
Other _____						

\*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations (such as United Way, sponsorship)
- ☐ Other (specify) \_\_\_\_\_

#### 4.4 How are you assuring CHIP enrollees have access to care?

- 4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in a Primary Care Case Management program, specify ‘PCCM.’

<b>Table 4.4.1</b>			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Appointment audits		<b>Not used</b>	
PCP/enrollee ratios		<b>Not used</b>	
Time/distance standards		<b>MCO</b>	
Urgent/routine care access standards		<b>MCO</b>	
Network capacity reviews (rural providers, safety net providers, specialty mix)		<b>Not used</b>	
Complaint/grievance/disenrollment reviews		<b>MCO</b>	
Case file reviews		<b>Not used</b>	
Beneficiary surveys		<b>MCO</b>	
Utilization analysis (emergency room use, preventive care use)		<b>None</b>	
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

\*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

- 4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

<b>Table 4.4.2</b>			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	___ Yes ___ No	<u><b>X</b></u> Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	<u><b>X</b></u> Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

\*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

- 4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

**None**

- 4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

**We have no unique plans for SCHIP. We use the same methods that are used to assure access to care for the Medicaid population. With the size of our state we depend on beneficiary reporting directly or through their eligibility workers, the Member Services Unit, their advocates, and their providers.**

#### 4.5 How are you measuring the quality of care received by CHIP enrollees?

- 4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in primary care case management, specify ‘PCCM.’

**We have nothing unique for SCHIP. We use the same methods that are used for the Medicaid population.**

<b>Table 4.5.1</b>			
Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)		<b>MCO</b>	
Client satisfaction surveys		<b>MCO</b>	
Complaint/grievance/disenrollment reviews		<b>MCO</b>	
Sentinel event reviews		<b>Not used</b>	
Plan site visits		<b>Not used</b>	
Case file reviews		<b>Not used</b>	
Independent peer review		<b>Not used</b>	
HEDIS performance measurement		<b>See attached draft</b>	
Other performance measurement (specify)			
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

\*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

- 4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

**Attached is a copy of our 1999 Consumer Satisfaction Survey.**

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

**We will continue to use the same methods that are used to monitor quality of care for the Medicaid population.**

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

- **Focused Studies - Pediatric Asthma Care, Diabetes Care, and Diagnosis of Affective Disorder in the Ambulatory Setting**
- **Quarterly Member Complaint and Grievance Report - Kaiser Permanente (MCO)**
- **Quarterly Member Complaint and Grievance Report - BlueFirst (MCO)**
- **Draft of HEDIS/EQRO indicators**
- **Consumer Satisfaction Survey - 1999**

**All reports, studies and surveys are for the entire Medicaid, Dr. Dynasaur, and SCHIP populations.**

## SECTION 5. REFLECTIONS

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This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

- 5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

**What Vermont has done in designing and implementing SCHIP is no different than what we have done in other initiatives expanding health care coverage to children. Vermont has long been in the forefront on such initiatives nationally. Before SCHIP, we were already covering children through 225% of the FPL with the use of 1902(r)(2) income disregards. When HCFA indicated that coverage for underinsured children would not be allowable under SCHIP with a waiver, we covered these children in the same SCHIP income group (225% to 300% of the FPL) through further use of these disregards and in conjunction with our 1115 demonstration project. We look upon health care coverage for children as a single initiative of which SCHIP is but a small part. From a public point of view, all publicly supported coverage for children in Vermont is Dr. Dynasaur.**

### 5.1.1 Eligibility Determination/Redetermination and Enrollment

**Eligibility Determination/Redetermination and Enrollment activities for SCHIP eligibles are the same as those covered by Medicaid under traditional rules, 1902(r)(2) disregards, and the 1115 demonstration project.**

### 5.1.2 Outreach

**The same outreach activities apply to all potential eligibles for all medical assistance programs.**

### 5.1.3 Benefit Structure

**With SCHIP as a Medicaid look-alike, the benefit package is the Medicaid benefit package.**

### 5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

**While our original application proposed premiums and copayments, we ultimately opted for premiums alone. Premiums are not unique to SCHIP. They also apply to the coverage of children in eligible Medicaid households with incomes above 185% of the FPL.**

#### 5.1.5 Delivery System

**All beneficiaries get the same program cards, assess care through the same benefit delivery systems, see the same providers, and get the same services. Only category codes assigned at the person level based on the eligibility determination distinguish the funding of the care and these are not apparent or even important to the eligibles.**

#### 5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

**Vermont's approach is the coverage of all children whether Medicaid or SCHIP. With eligibility processing handled in the same way; that is, by the same staff with the same automated support, Medicaid eligibility can be and is the first avenue for coverage. With providing coverage to the underinsured under Medicaid we largely eliminate the incentive to drop insurance. Then, for anyone with other coverage, creditable or otherwise, the same Medicaid third party liability activities apply.**

#### 5.1.7 Evaluation and Monitoring (including data reporting)

**The same evaluation and monitoring activities that apply to Medicaid apply to SCHIP. The level of participation for our higher income level beneficiaries who have proven to be generally low users does not justify a particular effort.**

#### 5.1.8 Other (specify)

**All non-specified functions or features that apply for Medicaid in Vermont apply to SCHIP.**

### 5.2 What plans does your State have for “improving the availability of health insurance and health care for children”? (Section 2108(b)(1)(F))

**Vermont does not currently plan any additional expansions for children. At 300% of the FPL our income levels are at the median income level in Vermont. Currently our health care programs cover better than 1 out of every 3 children under age 18 in Vermont. We cover better than 1 out of 2 of every child living in a household with incomes less than 300% of the FPL. While our actual participation is higher than we anticipated, that can be attributed to a greater interest in coverage at this income level. As it is, experience indicates that coverage is not always continuous and it need not be in a program that can provide immediate coverage when and if needs arise.**

5.3 What recommendations does your State have for improving the Title XXI program?  
(Section 2108(b)(1)(G))

**At the time of the enactment of SCHIP, Vermont had made significant progress towards the greater goal of universal health care coverage for children. SCHIP held out the possibility of additional federal resources to reach that goal. Vermont submitted but subsequently withdrew its original application largely because we believed that we could not justify the level of administrative support necessary to participate at our projected level of enrollment. We believed and it has been proven nationally, that this program requires the same effort whether the enrollment is 1,800, 18,000, or 80,000 participants.**

**As an alternative, we had planned to extend coverage to this group through the 1902(r)(2)/1115 approach. Ultimately, we agreed to reapply with the promise from HCFA and the White House that HCFA would recognize and address the administrative burden for states like Vermont, with limited resources and small enrollments. This promise has not been kept and we only have available a limited administrative claim under the program.**

**We find ourselves in a situation where the approaches to oversight imply that there have never been any initiatives to provide health care coverage to children including Medicaid. They largely ignore that highly successful program, applying unique requirements different from those that have been applied to Medicaid for over thirty years. This only magnifies the burden on states like Vermont where, out of necessity, the SCHIP administrative functions are shared among all programs. The result is an appearance that the program and its unique administration are more important than what was to be the goal, health care coverage for children.**

**Vermont has seriously considered withdrawing on more than one occasion but has persisted despite it all. If this continues, though, it will be clear that the administrative burdens outweigh the added FFP available under SCHIP. We again recommend that HCFA modify their requirements to accommodate the circumstances in which we operate and offer the flexibility we were promised and we expected when we originally reapplied to participate in Title XXI.**